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The picture of health

November 2002

How we are modernizing British Columbia's health care system

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MINISTER'S MESSAGE

We are very pleased to present our vision for British Columbia's health care system.

This is an important document, as it reinforces our strong commitment to a sustainable, high-quality health care system to meet the needs of British Columbians today and in the future. It describes the types of action we are taking – and will continue to take – in pursuing this most important of goals.

British Columbians expect to have a health system that works for them when they need it. A growing and an aging population; rising costs of labour, technology and drugs; and increasing demands have stressed the system and threatened its sustainability. Only by taking decisive action today will we be able to protect the system for future generations.

The time has come to take action - to build on the strengths of our existing system while strengthening its focus on promoting good health, responding to emerging priorities and doing a better job of meeting the needs of all British Columbians.

This document represents a new picture of health in British Columbia – a bold vision of renewal that is built on the health care principles we all cherish, but that reaches beyond 1960s solutions to meet the needs of patients today and tomorrow.

By moving forward with the changes described here, together we will build a health care system that inspires confidence and provides certainty to all British Columbians that there will be quality health care services to meet our needs.

Sindi Hawkins

Honourable Sindi Hawkins
Minister of Health Planning

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A Troubling Contrast

To most British Columbians, it's not new – media stories of a health care crisis highlighting tremendous pressures facing a system that simply wasn't built to meet 21st century demands.

Yet most B.C. residents also consider our publicly funded health system to be one of our greatest assets – a key part of what it means to be Canadian, and one of the reasons why British Columbians are among the healthiest people in the world.

How can it be that our health care system is so good, yet so troubled? So trusted, yet so much the focus of fear for its future survival?

The fact is that British Columbia does have a good health system, but it is one that was built for an earlier era. It is struggling to keep up with our changing needs, and it has become increasingly unsustainable financially as health care cost pressures have increased.

British Columbians have good reason to be both proud of our health system and yet concerned for its future. They may see a friend, neighbour or family member waiting for care, perhaps in pain and discomfort. They may see nursing shortages that close intensive care units, cause bed shortages and delay surgery. Residents of small towns and rural communities may see doctors leaving and vacancies remaining open for long periods.

And British Columbians know that health care costs are rising dramatically – now totalling $10.4 billion out of the provincial budget, fully 40 per cent of the total. Our publicly funded health care system now costs us $28.5 million per day.

We've got a quality health care system, but it's in trouble. The system is under tremendous and growing pressure.

Although it has served us well in the past, health care in B.C. is desperately in need of updating to make it more flexible, less fragmented, better organized, and financially sustainable.

"Controversy is a necessary element of change and should not be feared."

– BC Medical Association document, "Turning the Tide: Saving Medicare for Canadians," May 2001

Our health system is struggling because it is:

- unable to meet ever-growing demands for services;
- lacking a strong-enough focus of resources on high-quality patient care that improves health;
- lacking long-term planning that focuses on illness prevention and wellness strategies, instead of lurching from one crisis to another; and,
- becoming unaffordable for B.C. taxpayers, as a result of the increasing cost of new drugs and technologies, rising wage settlements, an aging population and a decline in federal contributions to health care.

Change is crucial

To improve and protect patient care in British Columbia, and to save our health system from financial disaster, British Columbia is embarking on an ambitious and wide-ranging strategy of health system renewal. These changes reflect the B.C. government's four long-term goals for our health care system:

- accessible, high quality health care;
- patient-centred public health care;
- improved health and wellness; and,
- sustainable, affordable health care.

The Picture of Health

To achieve health system renewal, we must:

- Organize a network of health services that gives all British Columbians access to acute care services, including emergency services in diagnostic and treatment centres and community health centres, within a standard time frame.

- Better serve the needs of people who are chronically ill, people with disabilities, and seniors, so they can be as independent for as long as possible and enjoy a high quality of life.

- Put a greater focus on health promotion and comprehensive approaches to preventing disease, rather than simply intervening once patients become ill. This means doing more to promote mental health; to prevent and control diabetes, cardiovascular disease, lung disease and cancer; and to prevent falls and other accidents by supporting British Columbians to make healthy choices about how they live.

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- Improve the health care working environment so we can recruit and retain the skilled health care professionals we need to continue providing high quality care.

- Build a well-designed health system that is accountable to the public for results and financially sustainable well into the future.

These goals are like pieces of a puzzle that – when combined – will create a robust health care system that serves British Columbians well. This document outlines how the B.C. government is working to fit the pieces together. It affirms our commitment to a health care system that is publicly administered, equitable, accessible, safe, effective and financially sustainable for all British Columbians – one that meets our needs at the right time and in the right place.

Old Model – Complex New Needs

Our acute care health model works well for sudden illness and injuries.

For more than 35 years, our health care system has ensured that the calamity of accident and illness does not place undue financial hardship on British Columbians, and that everyone, regardless of their ability to pay, has access to doctors' services and high quality, government-funded hospital care.

The system's focus on doctors and hospital care met the needs of the younger population of 1960s B.C. The system provided ready access to consultation, diagnosis and treatment for a given condition, allowing most patients to return to their old life until another bout with ill health or bad luck brought them into the system once again.

When B.C. first adopted public health insurance in 1967...

- 50 per cent of Canadians were under age 29 and only 2.1 per cent were over 80.
- Canada had the highest rate of smoking in the Western world.
- Birth control was technically illegal.
- Seat belts were optional accessories on cars, and infant car seats were non-existent.
- B.C.'s bicycle helmet law was 30 years away.

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Acute care: just one piece of the puzzle

Our acute care health model works well for sudden illness and injuries. Everyday in B.C., thousands of people see their doctors for a health complaint, undergo tests to find the cause of their symptoms, get prescriptions for effective drugs, or have successful surgery or chemotherapy that saves their lives or reduces their suffering. The results generated by our health system are among the best in the world.

"B.C. health system still excellent"

On May 24th I was involved as a cyclist in a car-bicycle accident with near catastrophic results... I suffered major neck damage where one cervical vertebra was crushed and two others were fractured. There were numerous other injuries to my hand and leg. My reason for writing is to relate how wonderfully the entire system works for me.

The doctors worked very hard in each of their specialties and in consultation with each other. As the extent of my injuries unfolded the team expanded as I was taken by air ambulance to Vancouver General. Thanks to the skill of the medics, doctors, as well as the follow-up care from a dedicated team of nurses and therapists, I escaped being a quadriplegic. The quality of care was exceptional in 100 per cent of the people I encountered....

As one specialist pointed out, I am also very lucky not to be living in the U.S. where I would also be dealing with the stress of astronomical medical bills or fighting with an insurance company that wishes to minimize its costs....

Dr. Erik Bentzon

Excerpt, letter to the editor, Times-Colonist, July 3, 2002

British Columbians' health care needs have changed over the last 35 years but our health system has been slow to catch up.

Health needs are changing

British Columbians' health care needs have changed over the last 35 years but our health system has been slow to catch up. Among many changes, our population has been aging and we have more chronic diseases that aren't fixed by a trip to the doctor or the hospital. We now realize that doctors and acute care hospitals represent just two pieces of a giant jigsaw puzzle of optimal health care services.

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Home care, drug plans, help for the dying, wellness programs, chronic care, and services such as physiotherapy and occupational therapy, provided outside of hospitals, have become just as important to British Columbians as the traditional core of the system. But none of them were factored into the Canada Health Act of 1984. The result is:

Fragmentation: A patchwork, uncoordinated system of services has evolved as our health system has struggled to deal with British Columbians' changing needs. Patients with serious illnesses sometimes must shift between doctors, hospitals, rehabilitation services and community care, often needing to negotiate a maze of services on their own. Many fall through the cracks. All this results in substantial personal, financial and social costs to patients and their families, and to the health system in the long run.

In 2001, B.C. spent more than $761 million on services for persons with diabetes, an increase of 14.5 per cent in just four years.

In 2000, B.C. spent $698 million on treatment for mental illness, or $1,080 per client.

Snapshot how our health system has changed . . .

# of procedures in B.C.	1967	2000/2001
Cardiac bypass	0	2,509
Cataract replacement	0	31,216
Hip replacement	0	2,874
Kidney transplant	0	166

The elderly need more options: Over the next 15 years, one in every six British Columbians will be 65 or older. Our senior citizens need a range of supports in the community where they can maintain independence, autonomy and quality of life.

Chronic conditions not well managed: Chronic conditions – such as heart disease, depression, asthma and diabetes – cause people pain, suffering and disability, and put them at high risk of life-threatening complications. Under our acute care model, chronic conditions are typically treated one crisis at a time, so individuals cycle in and out of hospital, lurching from one health crisis to the next. Long-term management that focuses on education, early testing, treatment and monitoring can help prevent complications before they lead to a health crisis.

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"I'm on call every day, everywhere from Smithers to Kitimat. I am on call for about 60,000 people every day."

Q:"What happens when you go on vacation?"

A: "When I go on vacation there is nobody here."

Testimony of Terrace cardiologist and internist, Dr. Barrie Phillips, before the B.C. Select Standing Committee on Health, October 2001

Acute care spread too thin: Our health system's focus on acute care has meant that every community wants a hospital, access to medical specialists and the latest technology. If too few people live in a community to adequately support the livelihoods of professionals and the maintenance of skills, patient care suffers. Doctors working as solo practitioners are constantly on call with no vacation relief; as a result, they often burn out and leave. Commonly, there is no one to cover for them on days off, so patients must be sent by ambulance to other small hospitals, only to be moved yet again because of staff shortages there too. X-ray or laboratory services may not be available; expensive equipment can't be in every small community. Low numbers of patients for surgery and other procedures lead to more risk of complications, poorer outcomes and even a greater risk of death. Clustering acute care services in regional hubs leads to improved retention of health care staff, better access to quality services for patients and better patient outcomes. Expanding the use of new technologies like telehealth can help reduce the gaps between our communities, and all communities need a stronger focus on prevention and disease management.

High-tech care not always the best care: Acute care has fueled the demand for high-tech and expensive medical treatments, drugs and equipment. In some cases, these technologies can dramatically improve patients' lives. But sometimes, simpler, less invasive techniques will do. High-tech, high-cost care must be used where it does the most good for patients. Supportive programs, such as palliative care, are best used for those whom high-tech care cannot help.

Long term prevention loses out to short term crisis management: Four relatively simple behaviours can reduce the majority of diseases and injuries affecting British Columbians: don't smoke; eat a healthy, balanced diet; drink alcohol only in moderation; and get regular physical exercise. However, when health care funds are limited, it is difficult to shift resources from immediate care

such as cardiac by pass surgery to save the life of a person right now, to invest in prevention programs that may save many more lives ten years from now. This reality has fueled a crisis-driven medical system that doesn't have the luxury of stopping, planning ahead and putting more resources into preventing the crises from happening.

> *"We could prevent up to 60 to 70 per cent of all cancers... up to 90 per cent of all heart disease, up to 60 per cent of all strokes, up to 90 per cent of all chronic lung disease, up to 90 per cent of all diabetes – all of the things that are filling up our hospitals, and our doctor's offices, and our graveyards."*
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Rising Health Care Costs: A Hemorrhaging Vein

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Every aspect of health care is experiencing huge cost pressures:

Scope of services: Each new technique or diagnostic test, each new disease like AIDS or hepatitis C, adds a new cost to our health spending.

Pharmaceuticals: Drug expenditures in B.C. are increasing by $300,000 every single day. Pharmacare, the public drug benefit plan, grew by 53 per cent over the past five years, while the total B.C. health budget grew by 44 per cent.

Labour costs: 80 per cent of acute care costs in B.C. go to labour costs. When $1.1 billion was added to the health budget this past year, $685 million went to cover fees and benefits to health care workers. The increase to doctors alone was greater than the entire budget for preventive care.

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Operating and capital costs: Facilities are getting old and must be constantly upgraded. Aging and obsolete equipment must be replaced at increasing cost. Even small but essential items – syringes, bandages and linens – increase in cost each year.

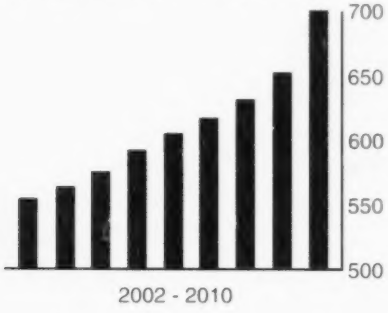
More people in B.C. are being treated each year but at a higher cost. Some examples:

- Over the last 10 years, the number of people having heart surgery increased from 2,500 to 3,300 per year. And the budget rose from $41 million to $55 million a year.
- The budget for organ transplants has doubled in seven years, with 220 cases per year now costing $25 million.
- Over the last six years, the number of people getting angioplasty procedures increased by 40 per cent to 4,200 a year, but the cost increased by 276 per cent.
- In the last six years, the budget for cancer drugs has increased by 320 per cent.

Technology: We've progressed over the last 20 years from x-rays to CT scans to magnetic resonance imaging (MRI). New technologies cost a lot to buy and a lot to operate. Emerging genetic testing and therapies are now becoming available that will further affect the health budget.

Our Aging Population

(B.C. senior population per 100,000)



Population growth: Over the past 20 years, B.C.'s population has increased by 45 per cent, contributing to a health care budget increase of more than five times that percentage.

Aging: As baby boomers age, the increased health care costs associated with an older population become more significant. Aging alone accounts for an annual increase in health costs of about one per cent, roughly the same as the impact of population growth.

Federal funding share declining: At one time, the federal government provided funding transfers equal to 50 per cent of hospital and medical care costs, which amounted to 25 per cent of total health care costs. Now, the federal government contributes only 41 per cent of hospital and doctors' costs, which amounts to only 15 per cent of total costs. The B.C. government has been forced to cover the growing shortfall on its own. This discrepancy is a major focus of talks between the provinces and the federal government.

Health spending outstripping revenue: If you combine all the money the Province collects from personal income tax, federal Canadian Health and Social Transfer payments and Medical Service Plan premiums, you still wouldn't have enough funding to cover the annual cost of B.C.'s health care system.

Health care reform in B.C. will not succeed if it is focused solely on saving money. Changes must reflect the principles of good patient care. And these two priorities – financial sustainability and quality care – can go hand in hand. For example, when the Australian state of New South Wales set out to provide a comprehensive, well-planned program to deal with depression, it was motivated by a focus on making quality the first priority. The result? A carefully designed and well-managed systematic prevention and treatment program ended up costing half as much as the previous haphazard system of care.

Health care reform in B.C. will not succeed if it is focused solely on saving money. Changes must reflect the principles of good patient care.

We already have a model in B.C. of coordinated care at its best. The BC Cancer Agency works with patients through early detection and diagnosis, treatment, support services and rehabilitation. Patients, no matter where they are in the province, move smoothly through each phase of their care, receiving standardized treatment based on the best available research evidence. In addition, the agency has centralized specialized services, such as radiation treatments, in four cancer centres (in the Interior, in Victoria and two in the Lower Mainland), so as not to spread resources too thinly. The result: British Columbia's cancer outcomes are the best in Canada, and our system of cancer care is a model for the rest of the country and the world.

B.C.'s 5-year Cancer Survival

- **Breast cancer**- 85 per cent of B.C. women are alive 5 years after diagnosis, compared with 82 per cent in the rest of Canada.
- **Prostate Cancer**- 91 per cent of B.C. men are alive 5 years after diagnosis, compared with 87 per cent in the rest of Canada

CIHI 2002 Health Care in Canada

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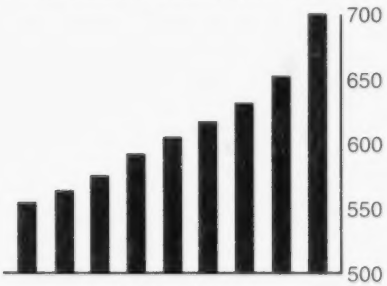

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B.C.'s 5-year Cancer Survival

- **Breast cancer**- 85 per cent of B.C. women are alive 5 years after diagnosis, compared with 82 per cent in the rest of Canada.
- **Prostate Cancer**- 91 per cent of B.C. men are alive 5 years after diagnosis, compared with 87 per cent in the rest of Canada

CIHI 2002 Health Care in Canada

Contemporary model needed for contemporary times

Rather than having a health care system focused on doctors' services and hospital admissions, we need to rebalance our picture and shift more focus to preventive programs that stop people from getting sick in the first place.

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Good health and high quality of life for British Columbians depends on more than just health services. It depends on a thriving economy, low unemployment and the ability to pay for other public programs such as education, social services and housing, all of which contribute to the health of our people. Our health care system is currently so expensive that other services are squeezed for public funding.

Achieving a balance

A good health care system has four essential ingredients: **health promotion, prevention, cure** and **care**. These have different time frames, cost profiles and actions:

Health promotion: Focus on individual and community participation and control over determinants of health, knowledge of health issues, choice about health care and building individual skills and resiliency.

Prevention: Focus on comprehensive, integrated strategies to reduce illness and injury in the whole population; results may not appear for years.

Cure: Focus on evidence-based tests and treatments shown to be effective and to improve patients' lives.

Care: Focus on the appropriate care – such as chronic disease management, home care, supportive housing, palliative care – for people with illnesses and disabilities that can't be prevented or cured.

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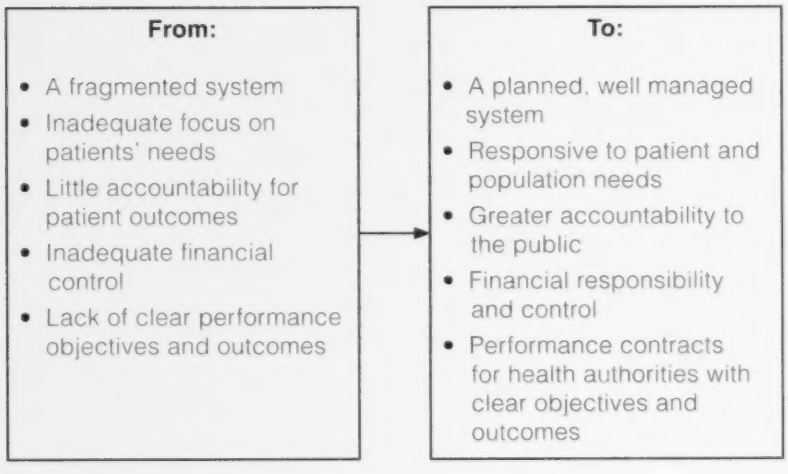
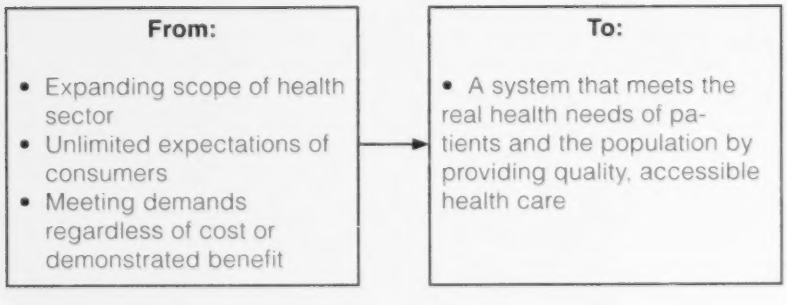
Strategic Shifts

The B.C. government is undertaking three major strategic shifts to build a sustainable health care system, and to enhance the health and wellness of British Columbians

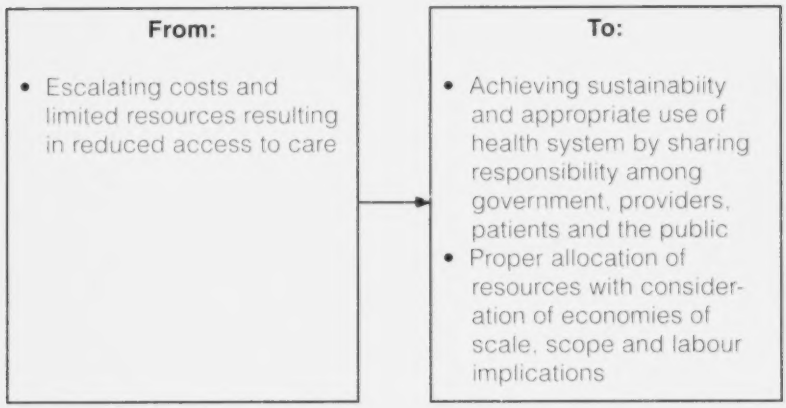
Better Planning and Management


From:
• A fragmented system
• Inadequate focus on patients' needs
• Little accountability for patient outcomes
• Inadequate financial control
• Lack of clear performance objectives and outcomes
To:
• A planned, well managed system
• Responsive to patient and population needs
• Greater accountability to the public
• Financial responsibility and control
• Performance contracts for health authorities with clear objectives and outcomes

Meeting Patients' Real Health Needs


From:
• Expanding scope of health sector
• Unlimited expectations of consumers
• Meeting demands regardless of cost or demonstrated benefit
To:
• A system that meets the real health needs of patients and the population by providing quality, accessible health care

Long-term Sustainability


From:
• Escalating costs and limited resources resulting in reduced access to care
To:
• Achieving sustainability and appropriate use of health system by sharing responsibility among government, providers, patients and the public
• Proper allocation of resources with consideration of economies of scale, scope and labour implications

Core Values

No one should face financial hardship because of illness, disease or disability.

The government has publicly embraced seven core values that, like a navigation system, will steer all health system reforms and ensure that we keep heading in the right direction.

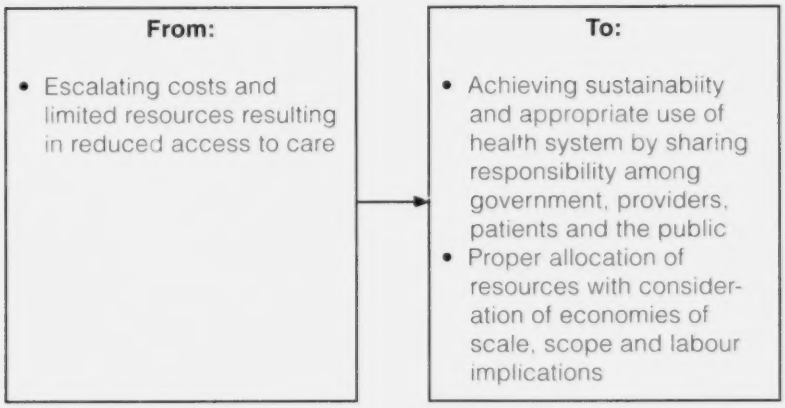
Patient and consumer focus: Services should be coordinated around patient needs for safe, timely and effective care. Health authorities and health workers must work together to put patient needs first.

B.C. study finds surgery not always appropriate nor helpful

A ground-breaking survey by former surgeon Dr. Charles Wright, released in 2001, followed 5,313 patients undergoing six common elective surgeries to see whether most doctors would agree that the patient needed the operation and whether, from the patient's perspective, it helped. The findings included:

- **Cataract extraction:** 31 per cent of patients had minimal visual impairment before surgery; 26 per cent reported worse vision after surgery.
- **Hysterectomy:** Doctors for 50 per cent of the patients undergoing the operation did not respond to the survey. Of the submitted data, 23 per cent of the operations did not meet accepted indications; the majority of patients said they were helped by the surgery, but 16 per cent said they were the same or worse.
- **Hip replacement:** 96 per cent of operations met the guidelines and 98 per cent of patients reported improved health after the surgery.

Long-term Sustainability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- **Hip replacement:** 96 per cent of operations met the guidelines and 98 per cent of patients reported improved health after the surgery.

Equity: No one should face financial hardship because of illness, disease or disability. Wealth should not be able to buy better treatment, higher-quality care or a better chance at a cure.

Access: We have become the first province in Canada to determine reasonable access to care no matter where one lives, by setting standards of travel time for acute care health services.

Effectiveness: We want a system that focuses on results for patients. Evidence can show us which services work and which don't. Those that don't should not be funded by the public system. Also, for the first time in Canada, B.C. has established performance contracts with health regions that hold them responsible for health results in their regions.

Appropriateness: The right procedures must be performed at the right time in the right place. The benefits of a given medical intervention must be weighed against the risks and downsides of the treatment. The right procedure must also be carried out in the right location – some procedures need a full service acute care hospital; others can safely be done in day surgery or even in a doctor's office.

Efficiency: Health care services must be managed and delivered at the lowest cost that is consistent with quality care. A well-organized, well-run system, with performance targets and an accountability structure, will go a long way toward exposing inefficiency and correcting it.

Safety: Medical error, adverse drug reactions and medical complications are all risks associated with health care. Safety means that the system is vigilant about preventing and correcting errors. Safety means establishing performance standards and monitoring patient outcomes. Two national research groups, the Canadian Institute for Health Research (CIHR) and Canadian Institute for Health Information (CIHI) are conducting a study of adverse events in 20 hospitals across Canada to better understand the scope of the problem.

Accountability and Performance Monitoring

The public has a right to know how and why decisions are being made and how and why dollars are being spent.

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For the first time in Canada, the B.C. government has entered into performance contracts with all of its regional health authorities. The regions will be required to report on how well they are meeting a list of performance targets, which are being defined for many areas of health delivery. The ministry has committed to meeting specific goals – from home care to aboriginal health. Wait times for treatments like surgery, radiation and chemotherapy, for example, must meet minimum standards. Follow-up treatment for the mentally ill must be measured and improved. Infant mortality for Status Indians must be reduced within a certain time frame.

Establishing meaningful targets is not easy. It takes time, research and planning. The targets must be measurable, meaning we must collect clear and relevant data to prove that the targets are being met. We need to design measurement tools that are accurate and reliable. We need to design information systems to allow the collection and sharing of data.

While complex, this approach – which represents a fundamental shift in emphasis – will help take often highly charged decision-making around health care services out of the political sphere and place it firmly in what research, evidence and professional judgment deem are best practices.

Performance Monitoring: A New Concept for Health Care

Almost 2000 years ago, Roman dramatist Seneca observed: "Our plans miscarry because they have no aim. When a man does not know what harbour he is making for, no wind is the right wind."

This sensible concept is the basis behind a recent revolution in health care: setting performance targets and monitoring whether they are achieved. The public is often astounded that health care systems in the past have not done this.

Now for the first time in B.C., the province has identified specific, measurable targets – such as decreasing the number of deaths in hospital from heart attack or stroke, or decreasing the number of elderly waiting in hospital beds for alternate care, or improving continuity of care by increasing the numbers of persons hospitalized for a mental health diagnosis who receive community or physician follow-up within 30 days of discharge – and are holding regional health authorities responsible through eight-page performance contracts for achieving specific targets.

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Patients must also be accountable. We need to be knowledgeable about our own health care needs, the steps we can take to keep healthy, and when it is appropriate to use the health care system. Services like the BC HealthGuide program, which includes a handbook explaining common health problems, and the 24-hour BC NurseLine, available in 130 different languages, can help patients make decisions about seeking care or treating themselves at home. A highly detailed computer database of current health information is now available on the Internet at **www.bchealthguide.org**. By entering a B.C. postal code, the user can get access to a wide range of health information about various illnesses and diseases, diagnostic tests, support groups and health agencies in B.C. Health Files is a series of more than 120 one-page, easy-to-understand fact sheets about public and environmental health and safety issues. These resources can help British Columbians become active and responsible partners in their own care.

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Working together across Canada

A final principle guiding reforms is the need to cooperate with other provinces in addressing issues affecting health care systems across the country. Some of the Canada-wide initiatives now being undertaken by the provinces and territories together include:

Common drug review process

All provinces are struggling to keep their prescription drug budgets under control. Each province has its own process of review to determine which drugs should be covered. This has led to a needless duplication of effort, inconsistencies in coverage, and decisions not always based on science. Pharmaceutical manufacturers, eager to get their drug listed, often use the fact that one province is covering it to exert public pressure on other provinces.

The Premiers have agreed to start a common review process to thoroughly assess the comparative safety, efficacy, and effectiveness of prescription medications. A common process to streamline the approval of generic drugs across the provinces is also under development.

Sites of excellence for low volume surgery

Rare operations like liver and double lung transplants, highly specialized pediatric surgery and neurosurgery such as gamma knife radiation, require unique equipment and highly trained teams of

health care providers. Canada is so physically large and its population so unevenly distributed that even large provinces might not have the population density to allow the safe delivery of low-volume, high-risk surgeries like these. In order to gain and maintain surgical expertise, surgical teams need to perform a certain volume of procedures each year.

Establishing sites of excellence will allow provinces to share human resources and set up centralized sites for these surgeries. While details are still being worked out, B.C. will likely host one or two of the specialized surgeries, such as pediatric cardiac surgery. For other specialized surgeries, B.C. patients could be sent out of province to the nearest site of excellence location, such as Edmonton or Toronto. A national plan will build on existing expertise and limited resources.

Human resources planning

All provinces face challenges in ensuring that there are sufficient nurses, doctors, pharmacists, lab technicians, physiotherapists and other highly trained allied health professionals in all regions of each jurisdiction. The premiers have committed to work with the Canadian Institute for Health Information to produce a Canadian database on human resource needs, training requirements and scope of practice to ensure a sustainable supply of health professionals to maintain patient care. Other strategies are also being developed among the provinces.

Premiers' Council on Health Awareness

Canadians need accurate and unbiased information about our health care system. All provinces and territories are funding the creation and operation of the Premiers' Council on Health Awareness, to be located in Ottawa. The council will help Canadians gain access to a wide range of health information.

The council's web site will provide all Canadians, including the public, health providers, researchers, educators and students with access to:

- provincial and territorial health data and links to provincial sites;
- Stats Canada data;
- global health research;
- information on health care reforms within Canada, such as those now under way in B.C.;
- Conference Board of Canada information; and
- a wide range of other health-related data.

Need health care information?

To talk to a registered nurse about a health issue, call the 24 hour toll-free information line:

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1-604-215-4700

Toll-free within B.C.:
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BC Health Care
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Chronic Disease Management
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BC Healthguide
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Programs and Initiatives
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Governance Change

Health Care as a B.C. Fortune 500 company

In 2001, our health care system had:

- 4 million residents with MSP coverage;
- more than 43,000 health care support workers;
- more than 27,000 registered nurses;
- 10,000 allied health professionals;
- more than 8,100 physicians;
- nearly 70 million medical services funded by the Medical Services Plan; and a
- $9.5 billion budget

"For years our health care system has been responding to immediate crises, like firemen pulling people out of burning buildings. It is tremendously important that we plan ahead for our future needs and that we create and initiate programs that stop people from getting sick in the first place, that deal with long-standing challenges like the unequal health status of our aboriginal people and that enable us to assess and plan for emerging issues like West Nile virus and new childhood vaccines."

- Dr. Perry Kendall, Provincial Health Officer.

Two ministries - four ministers

British Columbia's health care system is more complex, labour intensive and economically demanding than most of B.C.'s industries, and, indeed, many of the world's greatest companies.

In June 2001, the former Ministry of Health was restructured in an unprecedented manner, by splitting it into two: one ministry focused on the day-to-day management and delivery of health services, and a second focused on long-term policy and planning.

Ministry of Health Services

The Ministry of Health Services oversees the day-to-day operation of our health care system. Its role is to fund, monitor and evaluate health system performance against clearly stated expectations. The ministry funds and directs health authorities in the delivery of services, assesses health authority performance, and operates the two provincial health benefit plans (the Medical Service Plan and Pharmacare.)

Key priorities for the Ministry of Health Services for the next three years are:

- redesigning health care delivery, particularly acute care services, specialist services and laboratory services;
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The two ministries work together on a variety of strategies. Especially important for patients is primary health care. This includes chronic disease prevention, chronic disease management, and creating teams of family doctors and other health professionals that will monitor and manage patients' treatment to ensure they are getting the care they need.

For the first time in Canada, a ministry has been given the sole task of preparing for our future health needs, as well as developing policy, standards and legislation.

Ministry of Health Planning

For the first time in Canada, a ministry has been given the sole task of preparing for our future health needs, as well as developing policy, standards and legislation. This ministry is giving top priority to four current projects:

- developing a platform for health information management to address the crippling problem of data incompatibility, privacy and security;
- developing a 10-year human resources strategy;
- developing provincial population health and wellness initiatives to complement, strengthen and support core public health programs; and,
- developing an aboriginal health strategy.

Two ministers of state to focus on specific populations

Also for the first time in Canada, the B.C. government has appointed two ministers of state, one for mental health and one for home and community care, to give these issues a strong voice at the cabinet table.

The Minister of State for Mental Health works to ensure action on mental health services, advocate for mental health services throughout government, and establish a public information program on mental health issues and community services.

The Minister of State for Intermediate, Long-term and Home Care represents the housing and services needs of seniors and people with chronic illness or disability. The focus of the minister is to develop and strengthen various levels of support to help with activities of daily living and to provide safe and effective care options.

Regional Health Authority Restructuring

Prior to January 2002, B.C.'s regional health structure was the most complex in Canada, with 52 health authorities throughout the province. Now there are six: five representing geographic regions, and a provincial health authority to coordinate and deliver specialized health services to the entire province.

Prior to January 2002, B.C.'s regional health structure was the most complex in Canada, with 52 health authorities throughout the province.

By creating a more streamlined, cost-efficient, effective and accountable governance structure for health care in B.C., more resources can flow to patient care as a result of lower administrative costs and fewer bureaucratic hurdles.

In delivering the full continuum of care to their local residents (except for highly specialized services provided at the provincial level), the five regions now have the flexibility to make decisions about what programs and services best meet the needs of local people. That means health services that are more responsive to local needs, and better accountability to the people health authorities serve.

The five regional health authorities:

- Fraser Health Authority
- Interior Health Authority
- Northern Health Authority
- Vancouver Coastal Health Authority
- Vancouver Island Health Authority

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Provincial Health Services Authority

Provincial programs and highly specialized services account for about a third of the province's spending on hospital care. Although they serve the entire province, most of these services are delivered by agencies located in Vancouver, with a few delivered in large regional hospitals.

The Provincial Health Services Authority (PHSA) directly governs and administers the BC Cancer Agency, BC Centre for Disease Control and Prevention, BC Drug and Poison Information Centre, BC Mental Health Society (Riverview), BC Provincial Renal Agency, BC Transplant Society, Children's and Women's Health Centre of BC, and Forensic Psychiatric Services Commission.

Under the new model, the provincial authority works closely with the five regional health authorities and the ministries of health to coordinate programs and patient access. The PHSA board includes representation from each region, to ensure the regional perspective is included in governance, strategy and decisions.

Three-year block funding

As a transition measure, health authorities have been given the flexibility to balance budgets over two years rather than one. The health regions are allowed to run deficits in 2002/03, provided they run equivalent surpluses in 2003/04. For 2004/05 and subsequent years, the health authorities must balance their budgets each year.

Three-year block funding provides health authorities much greater flexibility than the past single-year budgeting, and encourages them to design innovative programs that improve services, apply savings from one program or year to another, or yield efficiencies two or three years down the road.

Population needs-based funding formula

Another first for the province: each region receives funding for acute care and home and community care based on the health care needs of the region's residents. Are there more elderly people in one region than another? Is there a greater rural population in one region than another? Funding must be based on need, because one-size funding does not fit all.

The population needs-based funding formula takes into account numbers of residents, age and distribution, socio-economic status, population growth, and differences in the cost of providing services. For example, it is known that people over the age of 75 tend to use the health system more frequently and women of childbearing age are also more frequent users, while costs are higher in remote areas.

When it was applied for the first time in the 2002/2003 budget, for example, both the Vancouver Island Health Authority and the Interior Health Authority got increases in their budgets, reflecting the relative needs of their populations, including those resulting from their relatively high proportions of seniors.

Consolidation of Acute Care Services

Regional health authorities are consolidating acute care services and creating inter-linked systems of small community hospitals or treatment centres for basic emergency services, larger community hospitals and regional referral centres.

Numerous stories in our media over the last five years tell of patients being shuttled by ambulance from one town's hospital to another because there was no doctor on call to read an x-ray at the first hospital, no surgeon to do the operation at the next, and a shortage of nurses at a third. Trying to maintain a high-functioning, high quality acute hospital in a community that does not have enough population to support health care professionals' livelihoods is proving unworkable.

This is being changed. Regional health authorities are consolidating acute care services and creating inter-linked systems of small community hospitals or treatment centres for basic emergency services, larger community hospitals and regional referral centres. Each of the five health regions, in concert with the Provincial Health Services Authority, is designing the network of acute care that makes the most sense in their region.

- In some cases, small community health centres or diagnostic and treatment centres will provide emergency services for all or part of each day. They will be able to triage and stabilize a patient, treat a heart attack or stroke, splint a fracture, do an x-ray or simple laboratory test, and give a treatment such as a prescription. Low risk maternity and elective day surgery may also be available. Support services such as doctors' offices, physiotherapy, home care agencies and education services for chronic disease management may be clustered together offering a "one-stop-shopping" locale for all health services to the community.

Why consolidate acute care services?

"It is not realistic to have a couple of ICU beds in Salmon Arm, a couple in Vernon, a few more here....It is not enough to effectively look after people in any one of those areas....You run into a shortage of critical physicians....You don't have enough intensive care nurses, respiratory therapists and all the support that goes with that. If you consolidate the finances, the physical space and
the human resources you actually provide better care, better access for patients. You improve things."

– Dr. John Just, general surgeon, Kamloops.

"I think it is very important to create a province-wide service plan, because with our big area, we don't have the critical mass to provide services in all places. Start to incorporate the idea of regional care centers."

– Dr. Marshall Dahl, internist, Vancouver; Chair, B.C. Medical Association; on health economics and policy.

"It is only by creating consolidation plans to centralize specialty and subspecialty physicians and surgeons that the increasing medical needs of the people of B.C. can be addressed in an acceptable fashion."

– Dr. Michael Humer, thoracic surgeon, Kamloops

- These centres will feed into a larger community hospital, centrally located to draw from all the surrounding smaller communities. The larger hospital will house inpatient beds and provide the most commonly needed specialty services such as high-risk obstetrics, general surgery, and pediatric care. It will have the staff and resources to handle more complex health needs and do more complex diagnostic tests.

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Fragmented care versus a coordinated network

Nine-year old Tom, from Castlegar, falls while biking and breaks his arm. Here' are two scenarios, one pre-consolidation, the second post-consolidation:

Old: His arm is examined by a doctor at Castlegar Hospital, but it needs to be set by a surgeon. The doctor calls Nelson, but the surgeon has left and no replacement has been found. The doctor calls Trail, but their surgeon is on vacation and no one is on call. Kelowna has a surgeon but no beds She calls Vernon where a surgeon and a bed are available. An ambulance is ordered. Time to locate the facility: 40 minutes. Time of ambulance ride to Vernon: 5 hours.

New: Tom is seen by the GP on call at the Castlegar community health centre. His arm is splinted and stabilized and he is given pain relief. The doctor calls ahead to the Kootenay Boundary Regional Hospital – where one of four surgeons is always available night or day. She tells them Tom is on his way. Time to make the call: 2 minutes; Time of ambulance ride to Trail: 25 minutes.

All the acute care hospitals in the region, from the lowest level of complexity to the highest, will be linked together as a network with an information connection, perhaps including teleheath capabilities, to create a more seamless transition of care.

- A third level of hospital, a regional referral centre, will also be in each health region, to handle more complex subspecialty care. All the acute care hospitals in the region, from the lowest level of complexity to the highest, will be linked together as a network with an information connection, perhaps including teleheath capabilities, to create a more seamless transition of care. Patients needing higher levels of acute care will still be moved by ambulance between hospitals, but waiting for them when they arrive at the higher level hospital will be, night or day, a full-time, qualified team of professionals prepared to ensure that their care needs are met quickly and appropriately.

Good plan – hard transition

The plan, while sound in terms of medical management, clinical best practices and cost-effectiveness, is nevertheless controversial and challenging to implement. Perhaps most controversially, it means changing the role of some acute care hospitals located in small towns. But the alternative is deteriorating care, services that are spread too thin, and the loss of health professionals in our communities.

The transition may be difficult for local residents, who may focus on what they are losing rather than on what the whole region is gaining. Similarly, it may be difficult for local health professionals, who may need to move or commute to a neighbouring community or adjust to different working environments.

However, consolidating our acute care services into a coordinated, stepped network of care will lead to better, more continuous coverage, better recruitment and retention of family doctors and specialist staff, improved patient care and a wiser, more cost-efficient use of resources.

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More services – like dialysis

Consolidation will mean more regional services, not less. Dialysis is a case in point. For years in the Northwest, people who developed kidney failure had to move to Prince George. For one patient, who developed renal failure last year, that has meant separation every week from his wife of 47 years. *"It has been a very stressful year for both of us,"* his wife said.

Now with the creation of network of smaller community hospitals supported by regional hubs for specialist acute care, Terrace will get a renal dialysis program, creating more options for people in the Northwest with kidney disease.

The B.C. government will be monitoring the impact of consolidation on patient health, on the delivery of services, and on the retention and recruitment of doctors and nurses. This way we can be sure the initiative is producing the desired results.

Access standards – A Canadian first

How close does emergency care need to be? How close must common specialty services be? New Zealand was the first country to ask that question and then systematically located services based on the answer. There, that meant 90 per cent of the population must be within one hour's travelling time of emergency care.

B.C. now has mandatory minimum requirements for stepped levels of acute care. Health regions must meet these standards:

Emergency Care: 98 per cent of the population must be within one hour's travel time or 50 kilometres of basic emergency care for stabilization and minor treatment or accident, illness, stroke and heart attack.

Inpatient Care: 98 per cent of the population must be within two hour's travel time or 100 kilometres of inpatient beds.

Specialty Care: 98 per cent of the population must be within four hour's travel time or 250 kilometres of core specialty services such as general surgery, anesthesia, psychiatry, internal medicine, obstetrics and gynecology and pediatrics.

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B.C. Ambulance Service

Did you know?

The B.C. Ambulance Service has bike squads of paramedics who provide emergency service and support at special events in Kamloops, Victoria and Vancouver.

A consolidated network of acute care services means that sick and injured patients must be moved quickly to the most appropriate hospital facility – a particular challenge in rural and remote parts of the province.

Fortunately, our province has excellent emergency health services through B.C.'s Ambulance Service, one of the largest ambulance services in Canada. The service employs more than 3,200 full and part time paramedics, and 150 management and support staff. The fleet consists of 424 ambulances and 191 stations. Air ambulance services are also on standby, with three helicopters, four turbo prop planes and one jet, available to transport patients between rural areas of B.C. and Vancouver and Victoria.

Recognizing the need for an adequately supported and funded service, the Ministry of Health Services has made available an additional $30 million above the present $188 million annual budget. It also:

- purchased 162 new or replacement automatic defibrillators, making this a standard item on all ambulances;
- funded 24 new paramedic positions, 16 of which will be placed in 10 small or semi-rural communities in the province; and,
- provided additional training opportunities to bring 1,500 paramedics up to Paramedic Level 1. This will ensure more timely and effective emergency care, particularly in rural communities.

The need for air ambulance dispatch to and from Vancouver is expected to diminish as more patients' acute care needs will be met in their own regions.

More steps will be taken in 2003 to decrease response times, improve the efficiency of dispatch, ensure staff training and increase cost-effectiveness of the services.

Volume of Calls

The B.C. Ambulance Service responds to an average 430,000 calls a *year. Of these:*

- 43 per cent – or 185,600 calls – are classified as emergency cases.
- 39 per cent – or about 168,000 cases a year – are calls requiring an ambulance but that are not necessarily time-sensitive or life threatening.
- 18 per cent – or 76,400 – are "transfer cases" in which stable, non-emergency cases are moved from one medical facility to another.

Strategies are being developed to allow alternative providers to conduct this important, but non-emergency, service to free-up B.C.'s highly trained paramedical staff and fleet to focus on true emergency situations.

Laboratory Services

British Columbia has the highest laboratory costs per capita in Canada. The reasons for this are complex. Our province has a mixed private/public laboratory system, with about 30 private firms providing laboratory services throughout the province. The rest are provided at government-run, usually hospital-based, laboratories. Differing payment models, frequent duplication of tests, unnecessary tests, and a lack of integration, cooperation and communication, have all contributed to higher costs.

The B.C. government is working to restructure and reform laboratory services, starting in the spring of 2003. The changes will be seamless and largely invisible to most British Columbians, although patients may notice they aren't going for the same tests twice in a short period of time. They may also notice that test results come back faster due to improved information exchange between labs and doctors' offices. The end result will be a more coordinated, collaborative and cost-effective system of laboratories that will translate into better patient care and better use of scarce health dollars.

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Chronic Disease Management

Effective management, including proactive medical care, helps people with chronic diseases keep healthy and independent for as long as possible.

A chronic disease is an illness that cannot be cured completely. Diabetes, depression, congestive heart failure, hepatitis C and asthma are all chronic diseases. An estimated 500,000 British Columbians suffer from one or more chronic diseases.

Effective management, including proactive medical care, helps people with chronic diseases keep healthy and independent for as long as possible. This is achieved through early detection, patient education and support programs and coordinated care to prevent complications.

B.C.'s health ministries are developing programs to address nine major chronic diseases in B.C.: diabetes, congestive heart failure, asthma, depression, high blood pressure, chronic lung disease, renal failure, liver disease and arthritis.

Elements of chronic disease management

The following tools and activities are used to monitor and improve care of chronic conditions:

Patient registries: British Columbians with chronic diseases will be encouraged to enroll in patient registries to allow health professionals to track their care, be proactive in scheduling them for tests and contact them with information.

Self-management products: Patient information guides, training programs, support groups, web-based access to information and other tools will help patients take charge of their illness. The BC NurseLine, BC HealthGuide and the Chronic Disease Management web site are some of the supports available to patients.

Collaboratives: Recognized experts, using the latest scientific research, will set standards of care, design flow sheets to manage each patient, set performance targets and identify patient actions.

Evidence-based practice guidelines: Doctors in B.C. will receive guidelines from the collaboratives, outlining the current recommended actions for the care and treatment of different chronic disease populations.

Performance monitoring: Monitoring the number of tests, charting patient satisfaction, following the hospital re-admission rates, and charting the utilization of services will enable us to set goals and see if we reach them.

Private/public partnerships: Initiatives with the pharmaceutical industry will support the implementation of chronic disease management.

Primary care and shared care models: General practitioners, working with other health professionals such as dietitians, counsellors, pharmacists, occupational therapists and specialists, will enhance the quality and coordination of care received by patients with chronic disease.

Diabetes and chronic disease management

A comprehensive chronic disease management program for diabetes will give diabetics and their doctors the tools and support they need to better look after their illness.

Diabetes is one of the leading causes of hospitalization, heart disease, stroke, blindness, kidney failure, and limb amputation in B.C. Its annual cost to health services in Canada is estimated at $9 billion.

In 2001, 30 per cent of people on dialysis for renal failure in the province were people with diabetes, a rate that has increased by 35 per cent over the last three years.

The complications of diabetes can be greatly reduced by strict control of blood sugar and medical care aimed at early detection of complications through regular eye exams, blood tests, lipid tests and urine tests.

The Medical Services Plan analysed billing claims for people with diabetes in 1999/2000:

- 38 per cent of people with diabetes did not get even one hemoglobin A1c test during the year
- 64 per cent did not have their lipids tested in the year
- 66 per cent did not have a retinal exam
- 74 per cent did not have a test looking for protein in the urine

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Primary health care

What do most B.C. patients want from their first contact with the health care system? Repeatedly, survey research has shown a similar picture of what people want:

- To see, within a reasonable time frame, the right health care professional to resolve their health concerns. It might be a doctor, a nurse (in the future, perhaps a nurse practitioner), a dietitian, a counselor, a physiotherapist, a specialist or others.
- One single point of entry into the health care system from which other types of care can be coordinated and scheduled.
- Minimal repetition of questions or tests.
- A doctor who works closely and communicates with other types of providers, each of whom knows what the other is doing.
- A health professional they can call or see for urgent care, 24 hours a day, seven days a week.
- Minimal waiting at one level of care for resources to be available at another.
- Proactive care in which they are contacted about necessary tests and referred to appropriate services that will provide education and support to prevent illness and/or manage their disease.
- Time spent educating them about their risk factors or disease so they can learn what they can do to improve their own health.
- Help and information – if they need it – to help them get access to appropriate community care or home care.

This, in essence, describes good primary health care. Over the past decade, a movement has emerged that is often called "primary health care reform." While there are a number of models being developed across Canada to improve primary health care, all offer more consistent, integrated and coordinated care for patients, a more collegial, supportive and rewarding working life for doctors and nurses, and more cost-effective care focused on preventing hospital admissions and supporting patients to take charge of their own health. Early results from demonstration projects across Canada are that physician satisfaction with their work improves, too.

B.C. has chosen not to restrict doctors' choices to a single model, but to help B.C. doctors embrace any number of models that work best for them and the region they work in. One size does not fit all.

Under the federal Primary Care Transition Fund, B.C. will receive $74 million over four years, which will be shared among the six health authorities. Funding is also available through an initiative with the B.C. Medical Association. Health authorities are being encouraged to apply for funding with initiatives that accomplish one of three primary health care goals:

Support a range of practice models such as primary health care networks of family doctors in different locations; shared care relationships between family doctors and specialists; augmented roles for nurses; or full service, primary health care organizations of multidisciplinary teams at one site.

Shared care: GPs and specialists under one roof

An inner-city clinic has a high number of patients with mental health concerns – depression, anxiety, addictions, family stress, concurrent disorders (mental health problem with drug or alcohol addiction) which is contributing to the overall ill-health of the patients. Three family physicians work together with a full-time psychiatrist and a mental health counsellor in the same clinic. The arrangement leads to better collaboration between health care providers, improved communication and better follow-up and ongoing treatment of patients.

Improve health outcomes through measures such as chronic disease registries; integration of clinical practice guidelines aimed at standardizing treatment of certain diseases; targeted disease or population strategies; and targeted high risk populations.

Research and evaluate primary health care projects. Health authorities will be able to study the results of initiatives so others can learn from the success or failure of programs like shared care arrangements or the development of electronic health records.

A renewed emphasis on primary health care aims to increase the range of services and expand patient choices, particularly in small town and rural B.C., and provide more options for the thousands of British Columbians who do not have a family doctor. The hope is that it will also improve the working lives of family doctors. We will be monitoring and evaluating these initiatives to ensure they are producing the desired results for the people and health professionals of B.C.

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Preventive Health

Many citizens are still at risk from factors such as poor dietary habits, obesity, inactivity, accidents and tobacco use.

While British Columbians are among the healthiest people in the world, we do not enjoy this status equally. Many citizens are still at risk from factors such as poor dietary habits, obesity, inactivity, accidents and tobacco use. The consequence is that vast resources are spent 'after the fact' – once a disease or injury has occurred. The key causes of preventable illness are:

Poor dietary habits – Hospital costs associated with poor dietary habits are about $80 million annually (as of 1997/98). Poor dietary habits also account for about 30 per cent of all costs related to cancer and diabetes, and 20 per cent of costs related to heart disease and stroke.

Tobacco use – While B.C. has the lowest prevalence of smokers in Canada, at 17 per cent, we can do better. Young people, particularly young women, age 15 to 24, have the highest rates of smoking at 19.9 per cent. Tobacco use costs the province about $1.25 billion per year in direct and indirect costs and accounts for 40 per cent of costs related to heart disease and stroke. A 1996 Health Canada report attributed 5,860 B.C. deaths in a single year to tobacco products.

Physical inactivity – 38 per cent of British Columbians over the age of 12 report that they do not get even minimal levels of physical activity. Of all direct health care costs in Canada, 2.5 per cent were associated with physical inactivity, as of 1999.

Preventable injuries – Causes of unintentional injuries include motor vehicle crashes, falls, poisoning, drowning and fires. Of these, falls account for the largest proportion of hospital costs – over three times the cost of treating injuries due to motor vehicle crashes. Every year, one-third of seniors experience at least one fall. Direct and indirect costs of preventable injuries are in the neighbourhood of $2.1 billion a year in B.C. – including more than $850 million in direct health care costs.

Overweight – More than 45 per cent of British Columbians are overweight (including those who are overweight and those who are obese), a rate that has doubled since 1985, and obesity-related illness costs the B.C. health care system an estimated $380 million annually, or 4.5 per cent of total direct health care costs in the province. Because smoking is gradually declining

and overweight is increasing rapidly, it is predicted that obesity-related costs will soon overtake the costs of tobacco-related illness.

Alcohol Abuse – Currently, 20 per cent of B.C. drinkers are regular, heavy drinkers – accounting for about 500,000 British Columbians. Half of all spousal assaults – 4,944 in 2000 – are alcohol-related. Alcohol is the leading cause of birth defects and learning disabilities in B.C., with an estimated 200 to 320 infants born each year affected by alcohol. ICBC statistics show 2,228 alcohol-related collisions in 1999, in which 3,407 people were injured and 96 died.

Suicide – More British Columbians die by suicide each year than by traffic fatalities, AIDS or illicit drug deaths. Suicide is the leading cause of death among young people aged 15 to 24. Suicide rates among youth tripled between the 1960s and the 1980s in B.C. and across Canada. British Columbia's suicide rate has been fairly stable for the past decade, averaging around 14 per 100,000 population each year. At least three times as many males die by suicide as females. There are more than 15,000 potential years of life lost due to suicide each year. For every death by suicide, there are likely between 50 and 100 attempts.

Focusing on falls

A single hip fracture for a senior can tip the balance into dependency, forcing a move from home into a hospital or residential care facility, sometimes followed by a rapid decline in health. The hip fracture alone adds between $24,400 to $28,000 in health costs to our health system. The province is co-funding three new initiatives totalling $362,000 that will focus on fall prevention:

Project 1 – Clinical Falls Assessment Tool: *A pocket reference guide is being created for doctors to help assess seniors at high risk of falls and to recommend preventive steps.*

Project 2 – Training: *A training module for home care workers helping frail seniors is being developed to help them recognize and reduce risk factors for falls.*

Project 3 – Surveillance: *A system for monitoring falls in long term care homes is now being tested in three facilities. Data on the nature and severity of falls will be collected to evaluate fall prevention programs in those facilities.*

If these programs prevent just 12 to 14 seniors from fracturing hips, they will pay back the provincial contribution.

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Project 2 – Training: *A training module for home care workers helping frail seniors is being developed to help them recognize and reduce risk factors for falls.*

Project 3 – Surveillance: *A system for monitoring falls in long term care homes is now being tested in three facilities. Data on the nature and severity of falls will be collected to evaluate fall prevention programs in those facilities.*

If these programs prevent just 12 to 14 seniors from fracturing hips, they will pay back the provincial contribution.

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Home and Community Care: Better Care, More Choices

In every poll that asks seniors and people with disabilities what they want, they say the same thing. They want to remain independent for as long as possible. They want a good quality of life. They want choices for the type of care they receive and where they receive it. They want government to provide a range of options. No one chooses to deteriorate or die in a hospital or institution. And yet, that is what happens to thousands of British Columbia seniors each year.

The facts speak for themselves:

- B.C. has a relatively high rate of institutionalizing its elderly – above the Canadian average;
- 70 per cent of home and community care costs are devoted to the 30 per cent of seniors living in long-term care;
- the percentage of British Columbians over the age of 65 will increase from 13 to 21 per cent over the next 25 years; and,
- the number of clients needing home and community care services will increase by about 1,600 people every year.

Relative costs to health authorities of care:

- $700 to $1,100 per bed per day for acute care in hospital
- an average of $125 per bed per day in residential care, which provides 24-hour-a-day support
- $50 to $75 per unit per day for assisted living options providing care support to seniors in specialized housing

B.C.'s Home and Community Care Strategy will see seniors and people with disabilities spending less time in acute care beds and residential care facilities, and more time supported at home and in the community.

A fundamental redesign of B.C.'s $1.6-billion home and community care sector is now underway. B.C.'s Home and Community Care Strategy will see seniors and people with disabilities spending less time in acute care beds and long-term care facilities, and more time supported at home and in the community.

Seniors and people with disabilities who are able to be independent will have more options, such as assisted living, where they are living in their own homes, whether apartments or specially designed units, receiving the health care support they need, and the services they want, to promote their independence and quality of life. Previously, a tangle of laws and regulations, including the Community Care Facility Act and the Hospital Act, governed the lives of some relatively independent people who simply didn't need the protection of such extensive government regulation.

Introduced in November 2002, the Community Care and Assisted Living Act gives local flexibility to govern facilities in ways that improve client care and open up new living options. Community care facilities continue to be licensed, while assisted living residences must be registered. Input was received from over 500 individuals and groups in developing the legislation.

Creativity meeting local needs: Gibsons Garden Inn

Faced with waits of more than 16 months for its two intermediate care facilities and no money to build a new facility, the then-Coast/Garibaldi Health Region partnered with a local, modern hotel to provide assisted living accommodation in 10 of the hotel's 50 rooms.

Just steps away from a movie theatre, shopping, and a bus route, the Gibsons Garden Inn had a garden courtyard, large rooms, pool, hot tub, exercise room, and restaurant.

The program, in which the local health authority provided 24-hour home support and the hotel provided accommodation, housekeeping and meals, cost just $34 a day for the health system and around $1,000 a month for the client. It proved so popular and effective with patients and the region that it has now been expanded. Now there are 19 rooms, two of which are devoted to palliative care patients.

The hotel's owner, seeing the demand for high-quality supportive care for elderly citizens that respects their independence, converted the hotel's other 31 rooms into supportive housing beds.

"For us it has been a very simple and practical solution to a long standing problem that has grown as our needs have grown," says Anne Marie Lasuta, manager home and community care, North Shore/Coast Garibaldi Health Services Delivery Area, which is part of the Vancouver Coastal Health Region.

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Home and Community Care

A growing range of home care options can help people remain at home. They include:

- home support (assistance with the activities of daily living);
- adult day-care programs;
- Meals on Wheels and other services;
- home-based palliative care;
- home care nursing; and,
- home-based rehabilitation (occupational therapy / physiotherapy).

Home care has traditionally provided basic services to frail seniors and people with disabilities to support independence, and to slow declines in health. However, it is increasingly playing a post-acute care support role for complex needs by providing:

- home intravenous therapy;
- hip rehabilitation;
- home oxygen therapy; and,
- quick response teams that respond to elderly citizens in a sudden health crisis, such as a broken arm. Preventing hospital admission can help prevent patients' loss of independence and mobility.

Saskatchewan estimates that it saved over $30 million per year in reduction of acute care bed use, mainly through the use of home care services like these.

Significant resources will continue to be provided for residential care of those who are dependent and vulnerable.

Long-term Care

There will always be a need for long-term care facilities for those seniors with the most complex care needs. That's why significant resources will continue to be provided for long-term care of those who are dependent and vulnerable, and it's why the B.C. government is upgrading and replacing long-term care beds.

The government has also removed the need for wait lists with the access policy for long-term care. Clients with the highest need and urgency for long-term care now have priority for the first available, appropriate bed. Eligibility is determined by a standardized, objective needs assessment that measures the ability of a person to perform tasks of daily living, including a measure of their mental capacity, their ability to be safe, and their caregiver's ability to provide care and support. This ensures that access to long-term care beds will be based on need. Seniors and people with disabilities will be confident knowing that when they need complex care, it will be available.

The missing link: Assisted Living

B.C. seniors who are well off have always had a wide range of private options for supported care in the community.

Now, the government's Supportive Living B.C. program will create 3,500 units over the next four years to meet the needs of low- and modest-income seniors who have health care needs as well. Federal support of $62.5 million under the Canada/B.C. Affordable Housing Agreement will be matched by provincial funds. The initiative, in partnership with B.C. Housing, will:

- retrofit 1,000 existing units
- create 1,500 specially designed non-profit units
- provide 1,000 rent supplements in private market supportive living developments.

New Range of Living Options

- **Home Care:**
  Supports independent living. Care is provided in the resident's existing home.
- **Independent Housing:** Provides housing, some meals, some housekeeping, emergency response and social activities
- **Assisted Living:**
  Provides housing, most meals, housekeeping, social activities, a limited range of medical care and assistance with activities of daily living.
- **Long-term Care:** Provides facility living with full-time professional health care 24 hours a day, seven days a week and is a licensed health care facility.

Publicly funded assisted living residences provide an additional option to seniors who do not require full-time professional care.

Publicly funded assisted living residences provide an additional option to seniors who do not require full-time professional care. They are integrated into communities and are usually situated close to shops, doctors' offices, and other amenities. Residents live in self-contained apartments, eat in common dining rooms, receive housekeeping and laundry service and have some common recreation and social space. Client fees under the assisted living program cover personal care services, 24-hour emergency response, social and recreational programs, and two meals a day. Fee-for-service might cover additional meals, help with shopping and so on, as residents choose.

Assisted living is an extension of the independent housing model for those who need assistance with activities of daily living, but only

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a limited range of medical care services. Residents live in their own suites, which they furnish with their belongings, and are supported in personal decision-making. Residences generally contain between 30 and 50 suites to avoid becoming institutional.

Accountability and performance monitoring to ensure resident satisfaction is an essential part of the new Home and Community Care program. Standards of care and housing quality throughout the province will be maintained through standardized operating agreements with care providers and the registration requirements under the Community Care and Assisted Living Act. This will help ensure consistency in service without being overly rigid or restrictive.

Palliative care

When life is drawing to a close, a special kind of respectful, holistic care is needed. Palliative care helps terminally ill patients and their families deal with the physical, emotional and spiritual aspects of dying. Good palliative care can take place on a hospital palliative care ward, in a hospice unit in a long-term care facility or in a person's home.

The B.C. government is committed to providing better choices for people at the end of life through:

Provincial End of Life Strategy: The B.C. government has engaged an expert panel to develop a discussion paper on end of life care. This will inform a provincial strategy examining how home care options can better serve the needs of terminally ill British Columbians.

The B.C. Palliative Care Benefits Program: The government has changed a policy that for years effectively penalized people who chose to die at home rather than in hospital. Previously, pain and other medications, and medical supplies and equipment, were paid for by the health system if the patient stayed in hospital, but not if they went home. Now, under the Home and Community Care Strategy, these items needed by home-based clients in the end stage of their life-threatening disease or illness are covered.

Payment to family caregivers in unique situations

A new B.C. policy now allows some family members in unique situations to be paid to provide care or support to a relative who is eligible to receive government-funded care. The policy provides new flexibility for clients in choosing their caregivers.

Payment to Family Caregivers in Unique Situations

Sarah is a 54-year-old woman with multiple sclerosis who lives with her elderly mother in a remote part of the province. Her mother's health is declining and Sarah's family want to make plans for Sarah's care when her mother can no longer provide for her. Sarah has a sister who is a registered nurse and lives in the same community. She works part-time but she would be willing to give up her job to care for Sarah if she could be paid to do so. Under the new policy, as a sibling who does not live with her sister she can be assessed as a family care home operator. If the sister meets all the requirements, she may be paid to care for Sarah.

Monitoring home and community care progress

The Home and Community Care Strategy will establish performance indicators to measure improvements. These will include:

- increasing the number of clients served at home in relation to those in facilities;
- reducing the use of acute care beds by seniors who could be served in the community;
- increasing the number of home care rehabilitation and nursing visits; and,
- reducing unplanned hospital admissions for hip fractures, depression and influenza.

Home and community care has been a poor cousin in our acute-care dominated health care system. In B.C., community and home services are now being recognized for their pivotal role in developing a sustainable health care system.

Pharmacare

Prescription drugs play a bigger role than ever in health care. They help manage disease, improve health and prolong life. Pharmacare – the provincial government's public drug benefit plan – helps British Columbians pay for needed and appropriate drugs. But Pharmacare's viability depends on its financial sustainability. In the five years from 1997/98 to 2002/03, the program's budget has grown by 75.5 per cent, a growth rate that exceeds every other major health care program.

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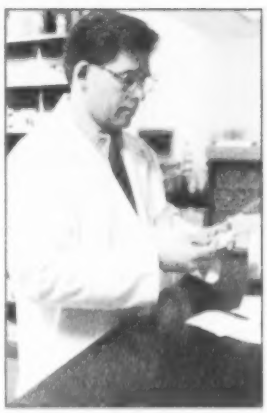

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Designer drug, high price

New drugs on the market can make a miraculous difference in patients' lives, but they don't come cheap.

Infliximab and etanercept are good examples. Released in 2001, these drugs often provide significant relief from the debilitating effects of rheumatoid arthritis in patients who have exhausted traditional therapies. In many cases, they allow people with rheumatoid arthritis to return to productive lives. However, the average cost of these drugs is $17,000 a year per person.

A number of problems are complicating the Pharmacare picture and contributing to rising costs:

Expensive new drugs: New, and usually more expensive, drugs are coming on the market every year. Few are major improvements over existing drugs. Of 566 new drugs that arrived on the market between 1995 and 1998, only 41 were "breakthroughs" that would substantially improve treatment of diseases.

More people taking more drugs: In B.C., someone is filling a prescription, on average, every four seconds. For example, the number of British Columbians being prescribed drugs for the treatment of mental illness increased by 7.3 per cent just from 2000 to 2001, with the associated drug cost rising from $91 million in 2000 to $106 million in 2001, a 16.5 per cent increase in a single year. In 2000, Canadians filled almost 291 million prescriptions at a cost of $11 billion. And yet, there are significant concerns about the appropriateness of some drug utilization.

Adverse drug reactions and medication misuse: Emergency room visits and hospitalizations of seniors due to drug-related problems cost the province more than $210 million a year. As many as 50 per cent of the medications used by seniors are not used appropriately.

B.C.'s actions for an effective, equitable and sustainable drug plan

How can we meet the prescription drug needs of our population and control drug costs? In B.C., Pharmacare's largest plan has covered the costs of drugs for one age group only, with most families receiving dramatically less assistance. This will be changing, as the B.C.

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government will be introducing a fairer and more equitable way to pay for the drugs we need – one that provides benefits to everyone, based on family income.

Government must hold the line on Pharmacare spending and make the program more responsive to the needs of British Columbians.

Government must hold the line on Pharmacare spending and make the program more responsive to the needs of British Columbians. B.C. is implementing or considering the following actions:

Increased deductibles: Deductibles within the existing plan that serves most families have been increased by $200. Now, every family in B.C. must pay the first $1,000 of drug costs per family per year. Pharmacare will pay 70 per cent of eligible costs between $1,000 and $2,000, and 100 per cent of costs over $2,000. Those receiving MSP premium assistance must pay the first $800; Pharmacare covers 100 per cent of costs over that amount.

Family income-based drug benefits: In 2003, B.C. plans to introduce an income-based drug plan. Under this plan, benefits for prescription drugs will be based not on a person's age, but on a person's ability to pay. A family income test will determine the amount of Pharmacare coverage that will be provided to each family. Care will be taken to protect those with low incomes, including the nearly half of seniors who now qualify for premium assistance. People on income assistance, seniors in long-term care facilities, and those in specialized plans such as the cystic fibrosis plan will continue to receive current benefits with no change. Detailed information on the plan will be developed in 2003.

Common Drug Review: Provinces will now be sharing one scientifically rigorous, evidence-based drug review process, rather than using their own processes. The Coordinating Office of Health Technology Assessment in Ottawa will oversee the common review.

Reference-Drug Program: Since 1995, B.C. has controlled some of its drug costs through the Reference Drug Program (RDP). When drugs within a certain category are known to be equally safe and effective, Pharmacare pays for the least expensive one – the reference drug. If the reference drug fails or is inappropriate, Pharmacare will pay for a more expensive drug if the doctor receives authority from Pharmacare.

HRT: More Harm than Good?

Not all drugs lead to improved health. By June of 2002, an estimated 6.8 million women in North America were taking hormone replacement therapy to overcome the symptoms of menopause and, it was thought, prevent heart disease and weakened bones.

In July 2002, U.S. researchers stunned the world when they stopped a study of 16,000 women three years early. The women taking HRT were showing a higher risk of heart attack, stroke, blood clots and breast cancer. While the drugs are still effective for hot flashes, vaginal dryness and insomnia, the researchers concluded that they should not be used for the prevention of heart disease and that the overall health risks, particularly for breast cancer, exceeded the drugs' benefits.

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The New Era document promised to "work with doctors, pharmacists and others to find a cost-effective alternative to reference based pricing." Accordingly, the Reference Drug Program underwent a review by an independent committee. The committee heard no alternate proposals and found that the principle of "therapeutic substitution" of the reference drug for others in the same category provides good patient care and saves money. This finding echoed earlier reviews of the program by the B.C. Auditor General, McMaster University researchers and Harvard researchers.

The committee recommended that a further, broader review of the program within the broader Pharmacare context might find alternatives. We accept the principle of therapeutic substitution and will work with doctors, pharmacists and those in the pharma-industry to conduct a final review. If no alternative can be found which achieves the same or better savings, it will be confirmed.

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Meeting Human Resource Needs

The B.C. government is developing a 10-year health human resources plan to address critical shortages in all health care areas. At times, a lack of professional staff has led to the closure of beds and intensive care units, the transfer of patients to other facilities, and the delay or cancellation of surgeries. We need to educate, recruit and retain our workforce to provide better service.

Educating and keeping our doctors

B.C. has more doctors per population than Alberta or Ontario, and more than the Canadian average, but they are not evenly distributed throughout the province. Our province does not always make the best possible use of the physicians we have, and we are losing our valued general practitioners. B.C. trains just 128 doctors a year, the lowest number per capita in Canada.

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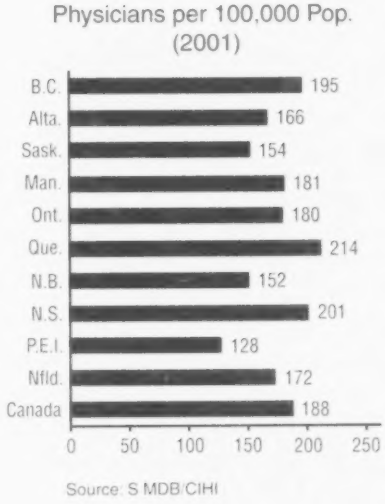

Source: S MDB CIHI

Thousands of British Columbians do not have a family doctor. It's difficult for some people to find a family doctor because:

- two-thirds of existing GPs are not taking new patients;
- many physicians are leaving their practices to join walk-in clinics, which do not provide comprehensive, ongoing care;
- many doctors no longer provide full service family practices, as they no longer do maternity or hospital-based care;
- some rural communities have a shortage of physicians;
- fewer medical graduates are choosing to go into family practice; and,
- the average doctor provides fewer services than doctors did in the past, particularly the 30 per cent of doctors who are women.

The B.C. government is taking the following actions to help address this problem:

Consolidation of specialist services in regional centres: At least three doctors of the same specialty will work in each regional centre, drawing on a larger pool of patients. This creates a reasonable call and vacation schedule to help prevent burnout, concentrate resources, and reduce physician frustration. As a result, family doctors in the surrounding communities will have more specialist services available for back-up and consultation.

The government is providing incentives to encourage family doctors in solo practice to join group practices with several other physicians, or to work directly with several nurse practitioners and other health professionals as a team.

Primary health care networks: The government is providing incentives to encourage family doctors in solo practice to join group practices with several other physicians, or to work directly with several nurse practitioners and other health professionals as a team. These networks provide doctors with support from other health care workers, and provide patients with access to appropriate levels of care. Early studies show that service providers' job satisfaction increases and stress can go down when these primary health care networks are used.

Increased education spots and locations: The government's Life Sciences Initiative will:

- increase the number of medical school places at the University of British Columbia. There are 128 this year; there will be 224 by 2005;
- increase the number of residency positions in the province; establish a new Life Sciences Centre at UBC at a cost of $110 million, with two satellite facilities at the University of Norther B.C. and at the University of Victoria, costing another $25 million; and,
- support a rural emphasis in doctor training. A significant number of students will be trained in communities outside the Lower Mainland, some in Prince George in the rural and remote medicine program, and some in Victoria, where the focus will be on geriatric medicine.

Improving compensation: Recently, the government negotiated an agreement with doctors that included an additional $392 million for fee increases, on-call compensation and a mechanism to resolve future disputes.

Compensation flexibility: The current fee-for-service system does not work well for many physicians. The provincial government is offering more flexible arrangements for these physicians, such as salaries and common service contracts for looking after a group of patients rather than paying the physicians for each service they provide.

The government is working with physician committees of the B.C. Medical Association to improve the working environment of doctors and find new ways to recruit and retain these key resources in our health system.

Allied health professionals

When it comes to shortages, doctors and nurses get the most media attention, but other health professional – also key members of the health care team – face many of the same challenges. Allied health workers include well-known professions such as pharmacists, physiotherapists, medical imaging and dietitians, as well as other less known occupations such as perfusionists, cytotechnologists and polysomnographic technologists. All told, there are close to 200 allied health occupations, each providing critical health care services to British Columbians.

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The Ministry of Health Planning is developing a comprehensive 10-year Health Human Resources Plan. The goal of this plan is to ensure the short-term and long-term supply and distribution of health care providers is consistent with population health needs and goals, at a cost British Columbians can afford. This plan will address recruitment, education, retention and work design of nurses, physicians and allied health workers.

Ministry staff coordinate efforts to ensure an adequate supply of all health professionals by working closely with health authorities, other government ministries, educators, employers, professional associations and unions. Government also participates in intergovernmental initiatives on health human resources across Canada. As one example, the ministry works on an ongoing basis with the Ministry of Advanced Education. In 2002/03, health science education seats were increased by 116 for medical laboratory technicians, sonography, radiation therapy, respiratory therapy and midwifery. In addition, 430 education seats were added for care aides.

Addressing the shortage of nurses

Nurses play a vital role in the care of British Columbians. Currently, there is a provincial, national and international nursing shortage:

- B.C. has fewer nurses per capita than every other province and territory except Nunavut;
- our nursing workforce is aging, with 50 per cent of nurses aged between 45 and 65. The average retirement age is 58;
- each week in B.C., 2,400 nurses are off the job due to illness or injury; and,
- nursing education has lagged; across the country, nursing education seats decreased by 50 per cent during the 1990s.

Surveys of nurses show that they want a satisfying and rewarding job that pays them well, offers opportunities and choices, and recognizes their essential contribution to our health care system.

In August 2002, the Canadian Nursing Advisory Committee issued a report, "Our Health, Our Future: Creating Quality Workplaces for Canadian Nurses." The committee outlined 51 recommendations to address challenges in the workplace.

"The implications of not acting now to resolve these nursing workforce issues are plain. The regulated nursing professions make up over one-third of the entire Canadian health care workforce, and the care nurses provide has direct and significant impact on outcomes for the patients, clients, and families the system is designed to serve."

- The Canadian Nursing Advisory Committee Final Report, page 3

Within two months of being elected, the B.C. government agreed to give nurses a 22 per cent pay increase, making them the highest paid in Canada.

The government response

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To address the physical demands of caring for bedridden patients, the government spent $15 million to buy better equipment such as patient lifts and hospital beds.

A Provincial Nursing Strategy is underway to recruit, retain and educate nurses. The program aims to bring more people into nursing, return former practising nurses to the job, and encourage nurses to stay active in the profession. The initiative:

Creates increased training positions: We've added 1,266 nursing seats in B.C.'s educational institutions between 2001 and 2003.

Forgives student loans: In return for working in areas of the province where there is the greatest need for five years, nursing and medical students will have all outstanding B.C. student loans forgiven at a rate of 33 per cent per year of practice.

Recruits foreign-educated nurses with specialty training. The strategy focuses on filling positions that have been posted and vacant for several months. Soon, about 50 nurses, mostly from Australia and New Zealand, will be working in B.C.

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Helps return nurses to the job: We'll help non-practising RNs and under-employed foreign-educated nurses in B.C. recertify for work. More than 465 nurses applied for funding, and 404 were approved for refresher programs.

Finds roles for injured RNs: Nurses on Workers' Compensation or long-term disability have skills, abilities and knowledge that our health care system needs. This program allows employers to customize positions to enable these nurses to return to the workplace.

Provides a nursing grant program: Innovative mentoring and preceptor projects can help new nurses, especially in rural areas, feel less isolated and more supported.

Allows nurses to upgrade their skills: Nurses in intensive care and emergency departments traditionally must leave their jobs and pay for their own skills upgrading. This initiative supported 315 nurses in completing specialty training in areas that are experiencing shortages.

Develops and regulates nurse practitioners: The Ministry of Health Planning and the Registered Nurses Association of B.C. are working together to develop a regulatory framework for nurse practitioners, who are able to perform many tasks currently done by family doctors. The province, in conjunction with the Registered Nurses Association of B.C., is expecting to begin regulating nurse practitioners as early as 2003.

Explores other innovative nursing projects such as First Call, where nurses treat non-urgent cases in rural emergency rooms, and the BC NurseLine.

$15 million was spent in 2001 installing bed lifts and providing new hospital beds to reduce the number of nurses injured on the job.

Individually, none of these measures will solve the complex set of problems that gave rise to our province's current nursing shortage. There is no magic bullet. But continuing with the basics of the Nursing Strategy over the long term will result in a more stable nursing workforce. And that's vital to ensure high quality health care for British Columbians.

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First Call: Using Nurses' Skills

Mary H. is an RN working in the emergency department of a small community hospital. Anyone who comes into emergency is first seen by Mary, who assesses the illness or injury and decides whether or not to call the doctor. A doctor is always available as backup.

As a certified First Call RN, Mary is able to treat a variety of minor conditions, including small lacerations that need stitches, insect bites, minor burns, nosebleeds, pink eye, uncomplicated urinary tract infections, ear aches, sprains and strains, sore throats and uncomplicated upper respiratory infections. Mary's presence in the emergency room allows the doctor to work in other areas of the hospital or catch up on sleep at home during the night and saves the health system money in doctors' billings.

Information Technology

Most interactions between patients and health care service providers are still recorded using paper and pen. Developing coordinated information systems for the health industry has been stalled by a number of difficult problems:

- Need for patient confidentiality: to ensure security and yet provide access to health providers across institutional boundaries.
- Need for compatible formats: to allow information sharing across systems and regions.
- Need for investment: to ensure that the technology is in place after years without this kind of investment.

Canadian Institute for Health Information

In 1991, a national task force highlighted the need for a coordinated approach to Canada's health information system. Out of that recommendation, the Canadian Institute for Health Information (CIHI) was formed.

Independent, national and funded by provinces and the federal government, CIHI collects data on all aspects of the health system from each province. It produces reports and analysis, such as its annual report on Health Care In Canada, which is featured each year in Maclean's Magazine.

Working closely with the provinces, CIHI's collection and analysis of data is working to improve the health of the health care system and the health of Canadians.

The Ministry of Health Services and the Ministry of Health Planning are developing an information management strategy with the chief information officers of the health regions. The goal is to make health information available to all British Columbians to help them improve their wellness, learn about illness, find appropriate health care providers, and become better informed about available options and treatment practices.

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Double Clicking on Health

Some day in the near future, British Columbians will be able to sit down at their home computers, type in their personal health number and a password, and gain access to a world of personal health options. They might have access to their health records and coordinate their care needs. They could book appointments, schedule tests, check lab results, print out their child's immunization records, link into community services or find a health care provider.

They may even be able to get specific information to help manage their chronic disease, such as help knowing when they will need certain tests and what they should be doing to maintain their health.

Telehealth

The B.C. Telehealth Program delivers both clinical and continuing medical education services. Using video conferencing technology along with secure image and data transfer, the program provides services to 30 urban, rural and remote communities across the province, in the areas of maternal and child care, trauma, and pediatric palliative care. Video conferencing technology is also used to provide mental health services to people across the province, with more than 40 sites planned for installation by the end of 2002.

Another example of telehealth is bcbedline, which consists of a 24/7 call centre and hospital bed registry web site. In the event that a patient must be transferred out of a hospital, bcbedline assists physicians by locating a receiving physician and bed to ensure the timely transfer of the patient to the appropriate level of care.

Pursuing Private-Public Partnerships

No word causes more anxiety than the word "private" in the context of Canadian health care. It suggests privilege and enhanced access for some and restricted access for others. The fear is that it will bring in two-tier medicine – one tier for the poor and another for the rich.

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"This idea of multi-tiered medicine – we are already there, let's not kid ourselves. When I go to the bedside to do a consult on a head injury patient, I'm hoping they did it in a car, because then I have ICBC to help me do a better job of rehab. If it's not ICBC, I'm hoping they did it at work, because then I have WCB. If they didn't do it at work or in a car, I'm hoping they happen to be a war vet, or an RCMP officer, or retired navy or army, or bothered to buy extended rehab medical... because otherwise I can't do a good enough job on their rehab."

—Dr. Jill Calder
Dialogue on Health, 2000

The fact is that private organizations have played significant and essential roles in our health care system since its beginnings. These include hospitals and private long-term care facilities run by religious organizations and service clubs, and two major private laboratories that provide services in our health system.

Private involvement also includes the architectural firms that design our hospitals, the construction companies that build them, the medical equipment companies that stock the supplies, and the pharmaceutical companies that make the drugs. All of these are private sector, for-profit companies.

Regional health authorities are examining the potential advantages of pursuing partnerships with the private sector to help deliver aspects of the health system. Guidelines for private-public partnerships have been developed to ensure that any increased role of private enterprise in health care will not undermine the equity and universality provisions of the Canada Health Act. That means clear rules, accountable transactions, enforceable standards, and profits that do not come at the expense of our health care system.

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Creative Partnerships

What might a public-private partnership look like that would benefit patient access and services?

The government might own a piece of land and lease it to an investor for $1 a year. The investor could finance, build and own a hospital on the land, which the govern-ment leases back for a certain term. The developer could be more creative than a strictly public agency. For example, they might build a small shopping mall on part of the site with a drugstore, a florist, a doctors clinic, a rehab clinic with physiotherapists, a home medical supply outlet, perhaps even a fitness facility.

The public gets access to health related services all at one location, the developer gets free land, and the government-run health care system gets a new building and a percentage of the revenues from the lot.

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Mental Health and Addictions Care – Serving Our Needs Better

Mental illness exacts a terrible toll on British Columbians:

- one in five adults experiences a mental illness at some point in their life;
- about 300,000 British Columbians see a physician each year for problems related to depression or anxiety;
- on average, patients with mental illness stay almost two and a half times longer in hospital than patients with other diseases; and,
- about 30 per cent of all acute care days are used by patients with a mental illness.

People with mental illness generally do not receive the same level of care and respect as people with physical illness, so they are more likely than the general population to also experience substance misuse, unemployment, homelessness and untreated physical illness. Mental illness is treatable, and with appropriate care and supports, people with mental illness can manage their illness better, reduce the degree of disability and achieve their full potential. We are determined to do better. The B.C. government is asking each health authority to undertake the following:

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- increase its early intervention capacity and lower the average age when a patient with serious mental illness is identified and treated by a physician or health service provider;
- reduce the number of days mental health patients must stay in hospital because alternative community services are not available; and,
- increase the number of patients who receive follow up care for treatment of mental illness within 30 days of release from hospital.

An addiction (alcohol or other drug misuse) is an illness and a health issue. Health authorities are encouraged to deliver a full spectrum of prevention, treatment and support services that meet the needs of people with addictions. The Province is developing a mental health and addictions framework that will include a vision for mental health and addictions in B.C., and identify provincial best practices for prevention and treatment services, in order to provide assistance and direction to health authorities.

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Revitalizing mental health services

British Columbia is working to address mental health needs through several key strategies:

Improving community-based options: The key to more effective and cost-efficient treatment of people with mental illness will be a range of community-based options for care, from public education to supportive residential care and home-treatment. Responsibility for addictions (alcohol and other drugs) services delivery was transferred to the health authorities in April of 2002. This will enable health authorities to better target services such as withdrawal management, outpatient, residential, day treatment, children and youth.

Innovative provincial tertiary care

In 2002/03, one of the key projects is the construction of two facilities for mental health rehabilitation in Kamloops to serve the Interior. The two home-like facilities each have 20 beds with flexible designs to accommodate the specific needs of each client. They are scheduled to open in the spring of 2003.

"By opening facilities like this in key locations around the province we are improving access to specialized mental health services," says Lynda Cranston, CEO of the Provincial Health Services Authority.

Mental health information for individuals and families: Understanding mental health and addictions issues and treating and managing mental illness and addictions requires that people who have experienced mental illness and/or substance misuse and their families, professionals, and the public have access to accurate, standard and timely information on mental health, mental illness and addictions, including information on evidence-based services, supports and self-management.

Implementing quality practices: To improve the health status of persons experiencing mental illness and addictions, we must increasingly focus on best practices – the mental health

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Implementing quality practices: To improve the health status of persons experiencing mental illness and addictions, we must increasingly focus on best practices – the mental health

and addictions services and supports that have been shown to be most effective. These include best practices in assertive community treatment, residential care and other community treatment including treatment of concurrent disorders and self-management.

Developing provincial tertiary services: The Provincial Health Services Authority, which currently administers the care being provided through Riverview Hospital, Forensic Mental Health Services and other provincial programs, is working with the five regional health authorities to plan the transfer of specialized provincial tertiary mental health services across the province. This will ensure that patients formerly transferred to the Lower Mainland for specialized assessment and treatment will be able to access the full continuum of mental health services closer to home.

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Child and youth mental health services: The Ministry of Health Services is working closely with the Ministry of Children and Family Development on the development of a child and youth mental health plan, and on improving transition of youth to the adult mental health service system and transfer of children and youth from hospital to community services.

Provincial depression strategy: Depressive illnesses are common, with depression being the second leading cause of overall burden of disease worldwide. B.C. has released the Provincial Depression Strategy – Phase One, which calls for improved awareness, early intervention, a collaborative care approach, a stepped care approach that matches the needs to the resources, and a chronic disease management approach, including self-management tools.

Provincial anxiety disorders strategy: Anxiety disorders are the most prevalent class of mental illness, affecting approximately one in every 10 adults, yet the chronic and disabling nature of these conditions is seriously underestimated. The Provincial Anxiety Disorders Strategy aims to achieve four goals: improved awareness; improved access to information and service; improved appropriateness of care; and improved outcomes for people with anxiety disorders.

Aboriginal Health – Toward Equality

Aboriginal people in B.C. have the worst health status in the province. They face higher rates of death, diabetes, tuberculosis, heart disease, HIV/AIDS and suicides than the general population.

Until now, there has been little information about the nature of B.C.'s aboriginal health challenges. These include the historical disadvantages of colonialism, racism, disease, and the loss of cultural traditions. They also involve poverty, unemployment, inadequate housing, and substandard infrastructure endemic to many aboriginal communities.

B.C.'s first report on the health of aboriginal people was released in the fall of 2002 by our provincial health officer. It provides the first indications of health status improvement in some areas, including infant and all-age mortality rates for Status Indians (the only aboriginal group for which death statistics are available) and life expectancy gaps for Registered Indians in Canada. It also provides much-needed information to help guide programs and policies.

The provincial health officer has recommended initiatives in the following areas of aboriginal health: early childhood development, substance misuse reduction, reducing death rates due to HIV/AIDS, diabetes prevention, reducing death rates due to injuries, and increasing access to primary health care.

One of the keys to improving aboriginal health is to encourage and support aboriginal students to work in health-related fields. Some initiatives include:

- The University of B.C. medical school began in 2001 to devote six spaces each year to aboriginal students.
- Funding has been provided to several aboriginal groups (including the First Nations Chiefs health committee, the United Native Indian Education Society and the Community Health Associates of B.C.) to promote health care careers among aboriginal people.
- Kwantlen University College received a grant to support an aboriginal summer health careers camp in 2001.

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Action to address the problem

The B.C. government recognizes the need to specifically target aboriginal needs.

There is no one single model that can be applied across the province to tackle the issue. Aboriginal communities in B.C. range from the isolated and rural communities of the North, to the Downtown Eastside in Vancouver. There are 21 aboriginal languages in B.C., 200 registered Indian bands, and communities ranging in size from fewer than 50 to 2,500 members.

Without change, the social and economic costs of the inequality in health for B.C.'s aboriginal people will continue to have serious impacts on B.C.'s health system and undermine the well-being of a large number of our First Nations people.

The B.C. government recognizes the need to specifically target aboriginal needs. Its initiatives include:

Aboriginal health plans: Health authorities are developing aboriginal health plans. These must be locally relevant to their regions, span three years and be updated annually. The plans are expected to provide a community profile outlining the nature of the aboriginal communities within their jurisdictions and to indicate active steps for co-operation and collaboration with the aboriginal communities in their regions. Each health plan must include concrete objectives to improve aboriginal health services within the region as well as means for evaluating services and programs.

Funding to health authorities: The Province has earmarked funds to health authorities under aboriginal health initiatives programs to address mental health, addictions and chronic disease prevention and management. In addition, a Provincial Aboriginal Tobacco Strategy has been developed and is currently being evaluated.

Promote education: Aboriginal people are needed on the front lines of health delivery: more aboriginal caregivers, more nurse-centred care, more traditional healing concepts and more community outreach. There are fewer than 200 aboriginal doctors in Canada and only 1,000 aboriginal registered nurses. Last fall, UBC announced it would reserve six spaces each year in its medical school for aboriginal students. There are also college education programs, outreach programs, university-First Nations education partnerships and community health representative programs to address the issue.

Jurisdictional clarity: In many cases, aboriginal people – Metis, status, non-status, on-reserve, off-reserve – have fallen through the health care cracks, bounced between federal and provincial disputes over responsibility. The government has directed health authorities to improve access to all services they deliver.

Address population health: Seven major aboriginal health issues have been identified by the provincial health officer: infant health, tobacco use, alcohol and drugs, HIV/AIDS, diabetes, injuries and primary health care. These issues require a holistic approach to health as well as prevention strategies, community involvement, cultural sensitivity and outreach.

THE ROAD AHEAD

The actions described in this document are key steps toward fulfilling our goal of a sustainable publicly funded health system that will meet the needs of British Columbians today and long into the future.

Clearly, our health system faces great challenges. It's a system that has taken on far more than was ever envisioned for it 40 years ago, and it's under pressure to do even more in the future. And while the system still serves us well, the pressures it faces are severe. Change is not an option – it is essential, if we are going to have a quality health system there when we need it in the future.

This document outlines a large number of actions to address fundamental issues facing the system. By acting now, we can protect the strengths of the system while making it more adaptable to changing needs. And we can be well-positioned to take advantage of opportunities, such as the current moves of the federal government to pursue new health care initiatives at the national level.

It will take courage and creativity to develop the solutions that we need for a healthy future. We will need to be farsighted and determined to develop new solutions and withstand the resistance that invariably comes when change takes place. Through it all, we must hang onto the vision that we can and will do better.

This program of health care reform represents a good start at addressing the most challenging issues that face our health care system today and in the future. By continuing to move forward, we will achieve our picture of health.

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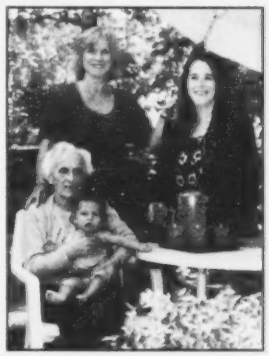

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